

State law rather than a law of the United States.

(2) *State*. For purposes of this section the term *State* includes a State, the Northern Mariana Islands, any political subdivisions of a State or such Island, or any agency or instrumentality of either.

[62 FR 16941, Apr. 8, 1997; 62 FR 31670, 31693, June 10, 1997. Redesignated at 65 FR 82142, Dec. 27, 2000]

**§ 2590.732 Special rules relating to group health plans.**

(a) *General exception for certain small group health plans*. The requirements of this part 7 of subtitle B of title I of the Act do not apply to any group health plan (and group health insurance coverage offered in connection with a group health plan) for any plan year if, on the first day of the plan year, the plan has fewer than 2 participants who are current employees.

(b) *Excepted benefits*—(1) *In general*. The requirements of subparts A and C of this part do not apply to any group health plan (or any group health insurance coverage offered in connection with a group health plan) in relation to its provision of the benefits described in paragraph (b)(2), (3), (4), or (5) of this section (or any combination of these benefits).

(2) *Benefits excepted in all circumstances*. The following benefits are excepted in all circumstances—

- (i) Coverage only for accident (including accidental death and dismemberment);
- (ii) Disability income insurance;
- (iii) Liability insurance, including general liability insurance and automobile liability insurance;
- (iv) Coverage issued as a supplement to liability insurance;
- (v) Workers' compensation or similar insurance;
- (vi) Automobile medical payment insurance;
- (vii) Credit-only insurance (for example, mortgage insurance); and
- (viii) Coverage for on-site medical clinics.

(3) *Limited excepted benefits*—(i) *In general*. Limited-scope dental benefits, limited-scope vision benefits, or long-term care benefits are excepted if they are provided under a separate policy,

certificate, or contract of insurance, or are otherwise not an integral part of the plan, as defined in paragraph (b)(3)(ii) of this section.

(ii) *Integral*. For purposes of paragraph (b)(3)(i) of this section, benefits are deemed to be an integral part of a plan unless a participant has the right to elect not to receive coverage for the benefits and, if the participant elects to receive coverage for the benefits, the participant pays an additional premium or contribution for that coverage.

(iii) *Limited scope*. Limited scope dental or vision benefits are dental or vision benefits that are sold under a separate policy or rider and that are limited in scope to a narrow range or type of benefits that are generally excluded from hospital/medical/surgical benefit packages.

(iv) *Long-term care*. Long-term care benefits are benefits that are either—

(A) Subject to State long-term care insurance laws;

(B) For qualified long-term care insurance services, as defined in section 7702B(c)(1) of the Code, or provided under a qualified long-term care insurance contract, as defined in section 7702B(b) of the Internal Revenue Code; or

(C) Based on cognitive impairment or a loss of functional capacity that is expected to be chronic.

(4) *Noncoordinated benefits*—(i) *Excepted benefits that are not coordinated*. Coverage for only a specified disease or illness (for example, cancer-only policies) or hospital indemnity or other fixed dollar indemnity insurance (for example, \$100/day) is excepted only if it meets each of the conditions specified in paragraph (b)(4)(ii) of this section.

(ii) *Conditions*. Benefits are described in paragraph (b)(4)(i) of this section only if—

(A) The benefits are provided under a separate policy, certificate, or contract of insurance;

(B) There is no coordination between the provision of the benefits and an exclusion of benefits under any group health plan maintained by the same plan sponsor; and

(C) The benefits are paid with respect to an event without regard to whether benefits are provided with respect to

the event under any group health plan maintained by the same plan sponsor.

(5) *Supplemental benefits.* The following benefits are excepted only if they are provided under a separate policy, certificate, or contract of insurance:

(i) Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act; also known as Medigap or MedSupp insurance);

(ii) Coverage supplemental to the coverage provided under chapter 55, title 10 of the United States Code (also known as CHAMPUS supplemental programs); and

(iii) Similar supplemental coverage provided to coverage under a group health plan.

(c) *Treatment of partnerships.* [Reserved]

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#### §2590.734 Enforcement. [Reserved]

#### §2590.736 Applicability dates.

(a) *General applicability dates*—(1) *Non-collectively bargained plans.* Part 7 of Subtitle B of Title I of the Act and §§2590.701–1 through 2590.701–7, 2590.703, 2590.731 through 2590.734, and this section apply with respect to group health plans, and health insurance coverage offered in connection with group health plans, for plan years beginning after June 30, 1997, except as otherwise provided in this section.

(2) *Collectively-bargained plans.* Except as otherwise provided in this section (other than in paragraph (a)(1) of this section), in the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before August 21, 1996, Part 7 of Subtitle B of Title I of the Act and §§2590.701–1 through 2590.701–7, 2590.703, 2590.731 through 2590.734, and this section do not apply to plan years beginning before the later of July 1, 1997, or the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after August 21, 1996). For these pur-

poses, any plan amendment made pursuant to a collective bargaining agreement relating to the plan, that amends the plan solely to conform to any requirement of such part, is not treated as a termination of the collective bargaining agreement.

(3)(i) *Preexisting condition exclusion periods for current employees.* Any preexisting condition exclusion period permitted under §2590.701–3 is measured from the individual's enrollment date in the plan. Such exclusion period, as limited under §2590.701–3, may be completed prior to the effective date of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for his or her plan. Therefore, on the date the individual's plan becomes subject to part 7 of subtitle B of title I of the Act, no preexisting condition exclusion may be imposed with respect to an individual beyond the limitation of §2590.701–3. For an individual who has not completed the permitted exclusion period under HIPAA, upon the effective date for his or her plan, the individual may use creditable coverage that the individual had prior to the enrollment date to reduce the remaining preexisting condition exclusion period applicable to the individual.

(ii) *Examples.* The following examples illustrate the rules of this paragraph (a)(3):

*Example 1.* (i) Individual A has been working for Employer X and has been covered under Employer X's plan since March 1, 1997. Under Employer X's plan, as in effect before January 1, 1998, there is no coverage for any preexisting condition. Employer X's plan year begins on January 1, 1998. A's enrollment date in the plan is March 1, 1997 and A has no creditable coverage before this date.

(ii) In this *Example 1*, Employer X may continue to impose the preexisting condition exclusion under the plan through February 28, 1998 (the end of the 12-month period using anniversary dates).

*Example 2.* (i) Same facts as in *Example 1*, except that A's enrollment date was August 1, 1996, instead of March 1, 1997.

(ii) In this *Example 2*, on January 1, 1998, Employer X's plan may no longer exclude treatment for any preexisting condition that A may have; however, because Employer X's plan is not subject to HIPAA until January 1, 1998, A is not entitled to claim reimbursement for expenses under the plan for treatments for any preexisting condition of A received before January 1, 1998.